IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

EDWARD HOLMES,	)	
	)	
Plaintiff,	)	
	)	02 C 7266
v.	)	
	)	Magistrate Judge Brown
DR. KUL SOOD,	)	
	)	
Defendant.	)	

PLAINTIFF'S THIRD MOTION *IN LIMINE*
TO BAR ALL REFERENCES TO PLAINTIFF'S PRIOR SUBSTANCE ABUSE

NOW COMES Plaintiff, EDWARD HOLMES, by his attorneys, LOEVY & LOEVY, hereby moves this Honorable Court for an order barring all references to Plaintiff's prior substance abuse. In support, Plaintiff states as follows:

Introduction

As the Court and the parties here all well know, evidence of substance abuse, particularly the use of street drugs, is, in some jurors' minds, a deal breaker. They are apt to view people who have abused drugs or alcohol categorically and moralistically, and would not "waste their valuable time" parsing the evidence for such a person. In other words, mention of addictions and substance abuse presents a serious danger that the case will be decided, not on its merits, but based on prejudice.

For that very reason, the defense here is set on trying to get such evidence in front of the jury. It would much prefer to turn this case into a trial about Plaintiff's prior drug and alcohol use to eclipse the uncomfortable facts about how Dr. Sood left Plaintiff to suffer in anguish and degenerate until his colon had to be removed at a hospital. However, that vain hope must be

rejected because the fact of the matter is that the defense has no genuine basis to argue that the evidence is relevant. Moreover, whatever contrived basis it concocts to argue that the evidence is relevant, it cannot show that the evidence is not unfairly prejudicial. As the party proffering the evidence, this is a burden that it must bear, but cannot meet.

The case law recognizes that attempts such as Defendant's here to interject evidence of substance abuse must be *very* carefully scrutinized by the courts. Moreover, Federal Rules of Evidence 401, 402, 403, and 404(b) all direct that the evidence be excluded absent a substantial probative purpose, a purpose which is lacking here. Accordingly, the Court should bar the evidence.

Argument

Recognizing the explosive potential for prejudice from substance abuse evidence, courts are extremely cautious and circumspect before letting it into a trial. *See, e.g., United States v. Cameron*, 814 F.2d 403, 405 (7th Cir. 1987) (approving order barring evidence of drug use because "there is considerable danger that evidence that witness has used illegal drugs may so prejudice the jury that it will excessively discount the witness' testimony"); *Alexander v. Cit Technology Financing Services, Inc.*, 217 F. Supp. 2d 867, 882 (N.D. Ill. 2002) (barring reference to fact that alleged sexual harassers were not punished for their abuse of drugs and alcohol at work because it was not probative of whether they were indulged to harass, would constitute improper character evidence, and because of "considerable" danger of unfair prejudice from the evidence); *Fletcher v. Conway*, No. 98-5183, 1991 WL 24460, at *2 (N.D. Ill. Feb. 21, 1991) ("Evidence of prior drug use is highly prejudicial. . . . Even had Conway advanced a proper theory for admissibility, any probative value evidence of past cocaine use may have in this

case is substantially outweighed by the potential of unfair prejudice. Past cocaine usage would serve to misfocus the jury's attention from the central issues in this case. Allowing Conway to introduce evidence to prove that Fletcher was a frequent cocaine user would create a trial within a trial on a collateral issue potentially consuming a great deal of time with only slight probative effect").

Courts are correctly wary of such evidence because parties can dream up all manner of grounds to claim that such evidence should be put before the jury, and often do so precisely because they desire the unfair prejudice. For this reason, the Seventh Circuit has warned that "[a] court must . . . be chary in admitting such evidence when it is offered" and take care that the proponent is not making tenuous claims of relevance in the real hope of getting the evidence in for "a general character attack." *Cameron*, 814 F. 2d at 405.

Here, Plaintiff was cognizant of the extraordinary danger of unfair prejudice from such evidence and concerned that Defendant may hope to misuse it. In accordance with LR 37.1, Plaintiff asked Defendant to agree that his history of drug and alcohol use was irrelevant and should not be mentioned at trial. Counsel for Defendant refused stating (when pressed) that they wanted to admit it to support an argument that Plaintiff's chronic colon condition (a condition called "ileus" which he suffered from long before he ever met Dr. Sood) was caused by substance abuse.

This claimed ground for admission presents a classic circumstance for the type of "chary" scrutiny the Seventh Circuit has prescribed. While it may seem logical at a passing glance, careful scrutiny reveals that the proffered purpose has no bearing on any matter that is of

consequence to this case.[1] The entire issue of how Plaintiff's ileus came to be is an irrelevant sideshow calculated to sneak in bad character evidence that the jury has no need to hear.

The fact that Plaintiff suffered from ileus is relevant to the case but the reasons why he developed ileus are meaningless.

It is undisputed that before Plaintiff came to the Will County Adult Detention Facility he had a chronic colon condition called ileus, which meant that his colon was often dilated and therefore poor at moving excrement through his system. *See* Exhibit A (Dr. James Franklin Dep.) at 53-54. Undoubtedly, the fact that Plaintiff had this condition is relevant to the case: Plaintiff asserts that Sood had to consider the ileus in his treatment decisions, and Defendant will no doubt want the jury to know that Plaintiff already had colon problems when he met Plaintiff so that they appropriately limit any award of damages to the additional injuries that Sood caused.

However, the reasons *why* Plaintiff developed the ileus are of no consequence to any matter at issue in the case and they are therefore inadmissible under FRE 401 and 402. There are multiple possible causes of ileus. It can result from prior intestinal surgery, surgery to other areas of the body under general anesthesia, use of *prescribed or illegal* narcotics, prior infections, or from unknown autoimmune problems, to name but a few. *See, e.g.*, Exhibit B (testimony of Defendant's expert Dr. John Clark) at 124-125, 128; *see also* Exhibit A (Franklin Dep.) at 40-41 ("sometimes it's not possible to identify the specific cause. Patients who have an autoimmune disease of the intestine, such as scleroderma, can develop dilation of the colon. There are many different possibilities").

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[1] Under FRE 402 only "relevant evidence" is admissible. FRE 401 limits "relevant evidence" to on that "evidence having any tendency to make the existence of any fact that is *of consequence* to the determination of the action more probable or less probable than it would be without the evidence." FRE 401 (emphasis added).

Importantly, regardless of the cause of the ileus, the treatment is the same. *See* Exhibit A (Franklin Dep.) at 155; Exhibit C (Dr. Ronald Himmelman Dep.) at 122. The reasons why Plaintiff developed his ileus are therefore irrelevant to whether Sood was deliberately indifferent to the condition by failing to take measures to decompress the colon or send Plaintiff to a hospital. Similarly, the source of the ileus is irrelevant to the issue of damages. What matters for damages is the fact that Plaintiff had a preexisting condition which he would have continued to suffer regardless of Sood's alleged misconduct. The reasons *why* Plaintiff suffered that condition have no bearing.

In short, the defense has no need to prove why Plaintiff suffered from the ileus. It cannot offer prejudicial evidence to "prove" something that is of no consequence to the case.

Separately, it is also true that Defendant fails to satisfy a necessary factual predicate to admitting evidence of Plaintiff's prior substance abuse. There are multiple potential causes of ileus in Mr. Holmes' history aside from substance abuse. He has had prior surgery to his colon, multiple hip replacements, and has been on prescribed narcotic medications for his orthopedic problems for a decade or more. *See* Exhibit A (Franklin Dep.) at 37 (prior colostomy), Exhibit D (Holmes Dep.) at 27 (hip replacements), Exhibit E (1996 medical record of narcotic pain medication - Tylenol 3).[2] Defendant offers no evidence to show how these various other matters did not cause or contribute to Mr. Holmes' ileus. For example, they have offered no basis to distinguish between the causative effect of Mr. Holmes' use of prescription narcotic pain relievers for his orthopedic problems versus his use of illegal street narcotics, and their own

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[2] Plaintiff's history of prescription narcotic pain relievers dates back significantly further than 1996, but he does not have medical records going back further than that date.

expert admitted as much at his deposition, stating:

> Q His condition was aggravated by narcotics generally whether prescribed or unprescribed; is that correct?
>
> A: Narcotics and alcohol.
>
> Q: But narcotics have the same effect on the colon basically whether they're prescribed or not prescribed; is that correct?
>
> A That's a reasonable conclusion.

Exhibit B (Clark Dep.) at 128.[3] Likewise, Plaintiff's expert Dr. Franklin also testified that the effect of the narcotics is the same:

> Q: Another way that you can lose that ability to expand and contract those muscles is through drug use and abuse, correct?
>
> A: Correct.
>
> Q: Specifically narcotics, correct?
>
> A: Correct.
>
> Q: And those can either be prescription or nonprescription, correct?
>
> A: Correct.
>
> Q: In other words, I can lose that by being a heroin addict or by having Demerol prescribed for me extensively, correct?
>
> A: Right.

Exhibit A (Franklin Dep.) at 36.

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[3] Not that Defendant should be permitted to force Plaintiff into a debate in front of the jury about whether, or the degree to which, substance abuse is to blame for his ileus versus the other potential factors because the entire issue is irrelevant and merely allowing in the fact of substance abuse engenders the dangerous unfair prejudice. Thus, Plaintiff could easily win the battle about whether substance abuse is to blame for his ileus but lose the war because the jury was told about his substance abuse in the first place.

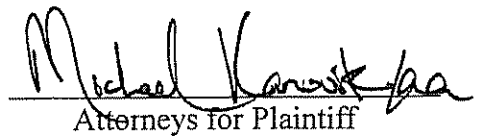
Conclusion

All of the above shows that Defendant has no need to put on evidence about why Plaintiff suffered ileus, and its proffered justification is simply a guise to inject unfairly prejudicial evidence of bad character. That is precisely the situation in which the Seventh Circuit warned courts to be circumspect and to reject substance abuse evidence absent very good reasons. Such reasons are lacking here and the evidence must be barred under FRE 401, 402, 403 and 404(b).

Local Rule 37.2 Statement

Prior to filing this motion, Plaintiff's counsel disclosed the motion to defense counsel, along with a short description of what specifically Plaintiff sought to bar and why. On March 21, 2006 at 3:30 p.m. at the location of the law offices of Charysh & Shroeder, Plaintiff's counsel, Michael Kanovitz and Amanda Antholt, met with Defendant's counsel, Michael Charysh and Richard A. Tjepkema, to discuss this motion. Unfortunately, after good faith attempts to resolve this issue, the parties were unable to reach an accord.

RESPECTFULLY SUBMITTED,



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IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

EDWARD HOLMES,)
Plaintiff,)
-vs-) No. 02 C 7266
DR. KUL SOOD and WEXFORD)
HEALTH SOURCES, INC.,)
Defendants.)

The deposition of JAMES L. FRANKLIN, M.D., called for examination pursuant to Notice and the Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before MARLENE L. RENO, C.S.R., a notary public within and for the County of Cook and State of Illinois, at 33 North Dearborn Street, Suite 1300, Chicago, Illinois, on the 24th day of June, 2004, at the hour of 11:30 o'clock a.m.

McCORKLE COURT REPORTERS, INC.
CHICAGO, ILLINOIS - (312) 263-0052

APPEARANCES:

24 A. I did not clearly see a statement of

1 that in the records prior to his hospitalization --
2 Q. Okay.
3 A. -- and prior to his incarceration.
4 Q. All right. So you don't know.
5 A. I don't.
6 Q. Another way that you can lose that ability
7 to expand and contract those muscles is through
8 drug use and abuse, correct?
9 A. Correct.
10 Q. Specifically narcotics, correct?
11 A. Correct.
12 Q. And those can either be prescription
13 or nonprescription, correct?
14 A. Correct.
15 Q. In other words, I can lose that by being
16 a heroin addict or by having Demerol prescribed
17 for me extensively, correct?
18 A. Right.
19 Q. Did you see anything in Mr. Holmes'
20 medical history that you reviewed that indicated
21 that prior to the events at issue in this case
22 he lost the ability to expand and contract
23 those muscles because of drug use or abuse?
24 A. The records indicate that he had problems

with intestinal motility prior to his incarceration and that narcotics appear to be an aggravating factor.

Q. In fact prior to his incarceration that's at issue in this case, at one point he had a colostomy, correct?

A. Correct, but the reason for that, he had a temporary -- he had resection of his sigmoid colon and a temporary colostomy, but as I read the records, they thought he had mechanical obstruction.

It's not 100 percent clear that that was the case in reviewing the records, but nevertheless that was part of the thinking from what I read in the record.

Q. If I lose the ability to expand and contract the muscles that we've been describing so that waste cannot be expelled, my colon can dilate, correct?

A. Correct. Although the line of your questioning implies that all passage of feces from the stool -- from the rectum would stop if the colon dilated, and that is not necessarily so.

Q. Now, I don't think we got to the point of you telling me what caused -- or strike that.

I don't think we got a clear answer on what it is that Ogilvie's Syndrome is. Is it just the inability to use those muscles?

A. Ogilvie's Syndrome is dilatation of the -- marked dilatation of the colon.

Q. When you say dilatation, you're talking about the --

A. Increased diameter.

Q. Like the garden hose we talked about.

A. Correct.

Q. And what causes that?

A. Well, it is a failure of the neuromuscular apparatus of the intestine, which may result from a variety of causes. For example, a patient who undergoes orthopedic surgery, such as a hip replacement, frequently such patients develop Ogilvie's Syndrome in the postoperative period, even though nothing has been done mechanically to their large intestine.

As an example, patients who abuse laxatives chronically may develop dilatation

D

of the colon, as you mentioned, and also long-standing narcotic usage can contribute to dilatation of the colon.

Sometimes the dilatation of the colon

can occur as a result of an infectious or inflammatory process of the colon, such as ulcerative colitis, or, for example, an amoebic infection or infection with Salmonellosis, and sometimes it's not possible to identify the specific cause.

Patients who have an autoimmune disease of the intestine, such as scleroderma, can develop dilatation of the colon. There are many different possibilities.

Q. You have never met Mr. Holmes, have you?

A. Correct.

Q. You never examined him?

A. Correct.

Q. Your knowledge of his condition is limited to the medical records that you have reviewed, correct?

A. Correct.

Q. Now, when did Mr. Holmes' Ogilvie's Syndrome arise, and what caused it?

A. It would appear that in the hospitalization in July prior to his being incarcerated he had a condition that sounded, from reviewing the records, that it might be a form of Ogilvie's Syndrome.

Q. Can you pin down a date and a cause with

precision?

A. Beyond what I said I don't think so.

Q. Okay. Have you reviewed all of Mr. Holmes' medical records?

A. In addition to the records that are indicated on the letter that I wrote on May 14, I did review the October hospitalization today, the complete hospitalization records.

Q. So prior to writing this report and rendering these opinions, you had not reviewed the complete records for Mr. Holmes' hospitalization at Silver Cross Hospital in October of 2001, correct?

A. Correct. I had reviewed a sampling of what was felt to be the pertinent records.

Q. And that sampling was given to you by Mr. Holmes' lawyers, correct?

A. Correct.

Q. They determined what they thought was important for you to look at, and they sent it to you, correct?

A. Correct.

Q. Did you ever ask them, "Do I have all of this man's medical records?"

A. I knew I didn't.

Q. Did you ask for a complete set of his medical records?

A. Yes.
Q. All right. The medical records from Silver Cross Hospital, which are on the table in front of us, correct?
A. Correct.
Q. And you also read the deposition of Dr. Darbandi, D-a-r-b-a-n-d-i, correct?
A. I did.
Q. And that's it?
A. That is it.
Q. All right. The next paragraph appears to indicate that you have certain professional qualifications and what you're doing currently over at Rush, correct?
A. Yes.
Q. So more or less sets out your qualifications.
A. Yes.
Q. The third full paragraph, which starts on Page 1 and continues to Page 2, basically gives some opinions -- strike that.
The third, fourth and fifth paragraphs

in your report contain your opinions, correct?
A. Not strictly. For example, the fact that his colon was dilated is a matter of record. The fact that he has abnormalities in fluid and electrolytes and low potassium were a matter of

record as well as the surgery that he had and surgical findings.

Q. All right. But if there are opinions, they're in those three paragraphs, aren't they?

A. That is correct.

Q. All right. Let's start with Paragraph 3. You indicate that based on your review of the records that you were provided Mr. Holmes suffered from chronic intestinal ileus and chronic pancreatitis prior to his incarceration, and you were basing that on his medical records from Silver Cross from July of 2001, correct?

A. Yes.

Q. What's chronic intestinal ileus, if you have to explain that to a layperson?

A. It's -- as opposed to something that has developed suddenly, something -- it is a condition that's been present for some period of time and involves dilatation of any portion of the

intestinal tract.

Q. What is an intestinal ileus?

A. It's dilatation of some portion or all of the intestinal tract without a mechanical obstruction.

Q. Okay. Is that different from Ogilvie's Syndrome?

A. Yes. As I have indicated, Ogilvie's Syndrome is an ep' -- is a specific condition involving dilatation of the colon, and it was originally described in a small number of patients with lung cancer before it was recognized that this could occur under many other circumstances, which is why the term has largely been dropped.

Q. Okay. Your opinion that Mr. Holmes had Ogilvie's Syndrome before his incarceration, is that a different condition than the chronic intestinal ileus that you're describing in this paragraph?

A. No. I don't believe I used the term Ogilvie's Syndrome. You've used it. And you were using it roughly synonymously with pseudo-obstruction of the colon, nonobstructive pseudo-obstruction of the colon. That is where

the colon is dilated and there is no mechanical obstruction.

(WHEREUPON, there was a short interruption.)

(WHEREUPON, a discussion was had off the record.)

BY MR. CHARYSH:

Q. When you use the term in your report "chronic intestinal ileus," is that different or the same as Ogilvie's Syndrome?

else?

A. I can see certain circumstances under which it would. For example, if a patient presents with ulcerative colitis and a distended colon, the treatment is different than if the patient has pseudo-obstruction of the colon.

If the patient suffers from underlying scleroderma of the colon, which is a rheumatic or inflammatory disease, the treatment is different, for example, than it would have been under these circumstances. So that some assessment of what the underlying cause is can affect the treatment.

Q. Okay. Now, what you've just described to me, though, am I correct to say that those are different conditions or diseases that would require different treatments?

A. They are.

Q. Okay.

A. But they are in a sense similar in that in both -- in all circumstances the colon is dilated and distended but not mechanically obstructed.

It falls into that category of nonobstructive syndromes of the colon. Some are idiopathic, which means that nobody knows the cause, and some are secondary to specific diseases.

Q. Okay. Now, to ask it sort of in a different way, if Mr. Holmes had the exact same condition in September and October of 2001, but it was caused or the underlying factors from years ago were something different besides narcotic use or alcohol use, would that change your opinions here?

A. No, because the treatment would still be the same even if narcotic -- if, for example, chronic narcotic abuse had contributed to the dilatation of the colon or this problem, one would still treat it in a manner along the lines that I've already outlined.

Q. Okay. You were also asked earlier in your testimony about the causal chain in the relationship of the subsequent surgery that

Mr. Holmes has undergone since the October 2001 surgery. Do you recall that?

A. Yes.

Q. Mr. Charysh asked you sort of but for question relating to that Mr. Holmes may have conceivably, even if none of this had ever happened, perhaps under some set of circumstances we can imagine he may have had to have similar surgery.

MR. CHARYSH: Objection. Mischaracterizes

IN THE DISTRICT COURT OF THE UNITED STATES
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EASTERN DIVISION

EDWARD HOLMES,	)	
	)	
Plaintiff,	)	
	)	
-vs-	)	No. 02 C 7266
	)	
DR. KUL SOOD and	)	
WEXFORD HEALTH SOURCES, INC.,	)	
	)	
Defendants.	)	

Deposition of DR. JOHN H. CLARK, JR. taken before KERI L. HOCHMAN, C.S.R., and Notary Public, pursuant to the Federal Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, at Suite 100, 312 North May Street, in the City of Chicago, Cook County, Illinois at 10:40 o'clock a.m. on the 9th day of September, A.D., 2004.

dilation of the intestines, and basically it can become a chronic state.

Q Okay. It can also be an acute state; is that correct?

A Yes. And that's frequently what we see in patients that have surgery. That's one of the post-op complications that we look for particularly in doing "gyn" surgery. That's why we try to get patients up out of bed and walking as soon as possible and ascertaining whether or not bowel sounds have returned and those kinds of things. So certainly that's something you may see as a part of the post-operative course in anyone who has had abdominal surgery.

Q Okay. What else besides abdominal surgery in the post-operative course can cause that kind of failure of the intestines?

A Well, there is the school of thought that suggests that certain types of substances both prescribed and illegal can impact on the intrinsic muscles and the motility of the GI track.

Q Narcotics can affect the neuromuscular --

A That's one category, yes.

Q Okay. Besides narcotics, the neuromuscular failure of the intestine can be caused by an assortment

of other factors as well; isn't that correct?

A Yes.

Q Okay. It can be caused by an infection or inflammation of the colon?

A That is true.

Q Okay. And oftentimes patients who have undergone orthopaedic surgery that have nothing to do with the abdomen will suffer similar problems?

A Yes. Any time you undergo general anesthesia, you know, that can cause a decrease in motility in the GI track.

Q Okay. Looking at your opinions that start on Page 6 and go to 7. You've given five opinions in the case. Does this report include all of the opinions you've made in this case?

A Yes, it does.

Q Okay. And the first opinion that you have listed here summarizes the complaints and presentation of Mr. Holmes; is that correct? Is that what that paragraph is doing?

A I don't know if it summarizes. I think it indicates that he presented with this history of chronic abdominal pain.

Q Okay. The second opinion that you have listed

can go hand in hand, or they can occur independently of each other.

MS. ANTHOLT: Q Because a patient has a chronic condition, you still look for acute symptoms and are aware of those processes; is that correct?

A Yes.

Q Okay. You indicate in the last part of number two that his condition was aggravated by abuse of drugs. His condition was aggravated by narcotics both prescription and possibly non-prescription; is that correct?

A Say that again.

Q His condition was aggravated by narcotics generally whether prescribed or unprescribed; is that correct?

A Narcotics and alcohol.

Q But narcotics have the same effect on the colon basically whether they're prescribed or not prescribed; is that correct?

A That's a reasonable conclusion.

Q Okay. So if a patient has colon problems, history of ileus and he's on narcotics being prescribed narcotics, do you as a physician take any special steps to monitor his condition or otherwise monitor the effect

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IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

EDWARD HOLMES)
Plaintiff,)
vs.) No. 02 C 7266
DR. KUL SOOD and WEXFORD)
HEALTH SOURCES, INC.,)
Defendants.)

The discovery deposition of DR. RONALD HIMMELMAN, taken in the above-entitled cause, before JANET O. DAVIS, a notary public of Cook County, Illinois, on the 16th day of June, 2004, at the hour of 11:00 o'clock a.m., at 33 North Dearborn Street, Suite 1300, Chicago, Illinois, pursuant to notice.

Reported by: Janet O. Davis, CSR
License No.: 084-001099

APPEARANCES:
LOEVY & LOEVY, by

specimen is in surgery. Saying it was collected during the surgical procedure.

Q So the surgery had to come before the pathologist report which was based on the specimen, is that correct?

A Yes.

Q Okay, thank you. You were also asked some questions earlier relating to causation factors of non-functioning colons in relation to narcotic use --

A Yes.

Q -- do you recall that? And you testified that narcotic use could be one contributing factor or causal factor of a non-functioning colon, is that correct?

A That's correct.

Q Could there be other causes for a non-functioning colon?

A Many.

MR. CHARYSH: I'm sorry?

THE WITNESS: Many.

MR. CHARYSH: Thank you.

BY MS. ANTHOLT:

Q Does your treatment and diagnosis of patients presenting as Mr. Holmes did during September and October of 2001, change based on what that initial causation factor was?

A No.

Q Okay. Would your opinions change or the steps you take to diagnose what is causing the symptoms change in any way because it was caused by narcotic use or is there something else?

A No.

Q Okay. Am I correct in saying that the report you have done on this case and the opinions

you have given in this case relate to the care given in September and October 2001 at the Will County Adult Detention Facility?

A Yes.

Q Okay. And in order to give those opinions did you need in any way to review documents that the Will County Detention Facility, the medical unit staff and Dr. Sood did not have during September and October of 2001?

A No.

Q And would those documents from either before that detention or after change your opinions in this matter in any way?

A No.

Q Mr. Charysh also asked you some questions earlier in the deposition if anyone or if Dr. Sood intentionally blocked requests for different medical treatment, do you recall that?

A Yes.

Q Is it your understanding that Mr. Holmes

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

EDWARD HOLMES,

Plaintiff,

vs.

No. 02 C 7266

WILL COUNTY SHERIFF BRENDAN D. WARD, in his official capacity, WEXFORD HEALTH CARE SOURCES, INC., unknown HEALTH CARE PROVIDERS, and unknown WILL COUNTY ADULT DETENTION FACILITY CORRECTIONAL OFFICERS,

Defendants.

The deposition of EDWARD HOLMES, taken before Eileen Bailey, a notary public in and for the County of DuPage and State of Illinois, taken pursuant to the Federal Rules of Civil Procedure for the Northern District Illinois, at Suite 195, 333 Pierce Road, Itasca, Illinois, on Wednesday, March 5, 2003, at the hour of 10:30 o'clock, a.m., pursuant to Notice.

Reported for
ADVANTAGE REPORTING SERVICE, by
Eileen Bailey, CSR, RPR

0002

APPEARANCES:

LOEVY & LOEVY,
(312 North May Street,
Suite 100,
Chicago, Illinois 60607), by:
312 243-5900,
MS. AMANDA ANTHOLT,
appeared on behalf of the Plaintiff;

HERVAS, SOTOS, CONDON & BERSANI,
(333 Pierce Road,
Suite 195,
Itasca, Illinois 60143), by:
630 773-4774
MR. JASON W. ROSE,
appeared on behalf of the Defendants,
Will County Sheriff Brendan D. Ward, in his official capacity, and unknown Will County Adult Detention Faculty Correctional Officers.

CHARYSH & SCHROEDER, LTD.,
(33 North Dearborn Street,

withdrawal problems. Do you recall that?
A. No, I don't remember that.
Q. Okay.
A. They don't take you to the hospital for drug withdrawal.
Q. I am going to read an inter-office communication dated March 15, 1990, from Deputy T. Kuzma to a Sergeant Canada.

MR. BURTON: What was the date?
MR. ROSE: March 15, 1990.
MS. ANTHOLT: And the Bates stamped number?
MR. ROSE: 1478. And this one is shorter. "On the above date at approximately 7:15 a.m. Inmate Holmes in cell 1-A was complaining he was sick. Deputy Gerrat reported Inmate Holmes was sweating and did look sick. The nurse was notified and Inmate Holmes was transported to Silver Cross Hospital." Do you recall being transported to Silver Cross Hospital sometime in March of 1990 while at the Will County Facility? You don't recall?
A. I don't recall, because they don't take you for withdrawal.
Q. It says, "Holmes was returned at approximately 10:30 a.m. He was treated for drug withdrawal problems. Inmate Holmes was put back in Cell 1-A." So, you don't recall this incident one way or the other, is that correct?
A. That's correct.
Q. And, again, just so we are clear, you are not saying you weren't taken to Silver Cross Hospital, you just don't have any recollection, correct?
A. I don't have any recollection.
Q. Okay. You have had hip surgery before, correct?
A. Correct.
Q. Right hip, or left hip, or both hips?
A. Both hips.
Q. Where was that?
A. St. Joe.
Q. Did you have both hips replaced at the same time?
A. No, I didn't.
Q. When were your hips -- when did you have the hip surgeries?
A. One in '89, I believe, and the other one the first part of '90. '91, '92.
Q. Do you recall which one was replaced first?
A. My right hip was replaced first, I believe.
Q. And both surgeries were at St. Joe's?
A. Yes, I believe so.

Q. Do you recall who your surgeon was?
A. Yes. Dr. Duffy, John Duffy.
Q. Did he do both of your surgeries?
A. Yes, he did.
Q. Have you seen Dr. Duffy for anything since that time?

Silver Cross Hospital
Joliet, Illinois

EMERGENCY DEPARTMENT RECORD

HISTORY NO. 161183
FINANCIAL NO. F3485778

PATIENT'S NAME: Holmes Edward
DATE & TIME OF ADM.: 11-25-96 1700
D.O.B.: 7-6-54 AGE: 42 SEX: M

MODE OF ARRIVAL: ☐ WALK ☐ W/C ☒ CART ☐ CARRIED
ACCOMPANIED BY: Joliet
☐ BLS ☒ ALS
☐ EMERGENT ☒ URGENT ☐ NON-URGENT

ADVANCE DIRECTIVES: ☐ DNR ☐ LIVING WILL ☐ DURABLE POA HEALTHCARE ☒ NONE ☐ UNKNOWN
DOCUMENTATION WITH PT. ☐ YES ☐ NO
LANGUAGE BARRIER ☐ YES ☒ NO
INTERPRETER (N/#):
GLASGOW COMA SCALE ☒ 15 ☐ <15 SEE NURSES NOTES

PRESENTING COMPLAINT/HISTORY, ONSET OF SYMPTOMS:
Pain to (L) thigh onset 1 Day ago pt also c/o blood in urine states refrigerator fell on leg on 11/24/96. Pt states has had blood in urine for a couple of weeks Pt 910X3 [illegible]
SIGNATURE: Darnowski RN

DISTRESS: ☐ NONE ☐ MILD ☒ MODERATE ☐ SEVERE ☐ ANXIETY ☐ BLEEDING ☐ PAIN ☐ RESPIRATORY
WEIGHT / kg: 86.18 ☐ ESTIMATED ☐ ACTUAL
HEIGHT / cm ☐ ESTIMATED ☐ ACTUAL
LAST TETANUS ☒ N/A
LMP ☒ N/A

ALLERGIES TO MEDICATIONS: NKA
(REACTION:)

VISUAL ACUITY ☐ N/A ☐ CORRECTION ☐ NO CORRECTION
OD / OS / OU: / / /
WEARS CORRECTION ☐ YES ☐ NO

TIME	TEMP	B/P	P	R	INITIALS
	98.6	150/110	122	20	[illegible]

ATTENDING PHYSICIAN: NOS Duffy

PHYSICIAN CALLED	TIME	RETURN	ARRIVED
Bhalla	18:46		

MEDICATIONS/DOSAGE	FREQ	LAST DOSE	MEDICATIONS/DOSAGE	FREQ	LAST DOSE
Ventolin					
Tylenol #3					

P.M.H. ☐ NONE ☒ ASTHMA ☐ BRONCHITIS ☐ CHF ☐ COPD ☐ CRF ☐ DIABETES ☐ HTN ☐ MI
☐ OTHER: Ulcers, (B) Hip replacement

HISTORY TIME AM PM

PHYSICAL EXAM

Dictated

☐ SEE SUPPLEMENT ☒ SEE DICTATION

TESTS	PROCEDURES / IV'S / MEDS / TREATMENTS	INITIALS
CBC, PT PTT / Amylase, ETOH, Lytes, U/A, X-ray (L) knee & tib fib	NG lavage	
	Thiamine 100mg IM	
	[redacted]	

DIAGNOSIS: GI bleed / alcoholic Gastritis.

DISCHARGE INSTRUCTIONS

DISPOSITION
CONDITION ON DISCHARGE ☐ GOOD ☐ FAIR ☐ SERIOUS ☐ CRITICAL
MODE OF DISCHARGE ☐ VIA SELF ☐ RELATIVE/FRIEND ☐ OTHER
☐ HOME ☐ DIE ☐ DOA ☐ LWBS ☐ AMA ☐ ADMIT ☐ OBV
TO DR. Bhalla (ATTD) (ADM) (OTHER)
TIME 1930 ☒ ROOM NUMBER 2117
☐ TRANSFER TO VIA

TRIAGE / INSURANCE
TO ED TX / ROOM
TO X-RAY / RTN X-RAY
ADM CALL 1905 / RM ASSIGN 1910
NOTIFIED ☐ RELATIVE ☐ POLICE ☒ NURSING HOME
TIME / INITIAL

PHYSICIAN SIGNATURE: [signature]
RN SIGNATURE
RN SIGNATURE: Darnowski RN

03512 10/95

WHITE - PG.1 - MEDICAL RECORDS   WHITE - PG. 2 - INPATIENT CHART   CANARY - PHYSICIAN BILLING   BLUE - INSURANCE   PINK - ATTENDING PHYSICIAN